

MENTAL HEALTH

*Balance  
the basics*

PRE-BUDGET SUBMISSION 2019-2020



**WAAMH**

Western Australian Association  
for Mental Health

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# 1. Summary of Commitments Sought

## Resourcing

- A. Proceeds from the divestment of Graylands are re-invested back into the mental health system.

## Priority Area 1: Effective Mental Health and Suicide Prevention

- B. New prevention investment in 2019-20 to reach the unmet 2017 state funding target of 2% and demonstrated increases over the Forward Estimates to reach the target of 4% state funding by 2020-21.
- C. Guaranteed continuity of funding for all programs under Suicide Prevention 2020, while a new Suicide Prevention Strategy is developed. Funding should match this year's resource allocation to Suicide Prevention 2020, equivalent to \$25.9 million over 4 years.
- D. A new Suicide Prevention Strategy co-designed and completed by December 2019 to direct future strategy and investment.

## Priority Area 2: Accessible and Responsive Community Support

- E. A planned program of incremental and staged state growth funding in community support, including accommodation with linked support, over five-years, that demonstrates how government will move towards meeting the modelled demand for services, with specific and staggered growth figures in the Forward Estimates.
- F. Procurement reform and targeted capacity building to support and improve the relevance of existing funded programs to the local and cultural needs of Aboriginal, rural and remote communities.

## Priority Area 3: Accommodation with linked community support

- G. New resources to complete the foundational reform work set out in the draft Accommodation Support Strategy to ensure existing accommodation services with linked support are integrated with clinical services, provide transition and flow between different options, and improve people's mental health outcomes.
- H. Cost: \$295,000 over two years.
- I. Ensure that Commitment E - a planned program of incremental and staged state growth funding in community support over five-years – includes growth in accommodation with linked support.

## Priority Area 4: People most in need

- J. Growth in community support, accommodation with linked support and prevention funding ensures the needs of vulnerable groups are prioritised in planning and delivery of new options.

## 2. About WAAMH

WAAMH is the peak body for the community mental health sector in Western Australia and exists to champion mental wellbeing, recovery and citizenship. WAAMH recognises a continuum of supports - built on principles of human rights, recovery, co-production, personalisation and choice, social inclusion and cultural connection - are essential to the promotion, protection and restoration of mental wellbeing. WAAMH promotes, advocates for and further develops this network of supports.

At the Western Australian Association for Mental Health (WAAMH), we have a vision that our state can lead the nation in addressing mental health in our communities through:

- Good foundations for emotional and social wellbeing for all Western Australians, wherever you live and whatever your age
- Ensuring there are great services in the community so people can get help for mental health concerns where and when they need it
- Protecting the rights of the most vulnerable people with mental health concerns in our society.

As the peak body for community mental health, we are a crucial conduit in bringing together the many stakeholders in this area to work towards our shared vision by advocating for and optimising the mental wellbeing of those who live here.

We proudly represent the voices of the many community-managed service providers and Western Australians who want to see this vision become a reality.

### 3. About this submission

This submission offers recommendations tightly focused on the state government's responsibilities in relation to the key parts of our mental health system that are most underdeveloped: prevention and community support.

Significant increased effort and investment by state government in these areas is needed to develop a more balanced system that can improve outcomes for people experiencing mental health issues and contribute to a sustainable health system.

WAAMH's recommendations have been informed by a range of activities including:

- WAAMH's ongoing involvement in reform and development processes;
- consultations on rural and remote mental health, community support, prevention and suicide prevention;
- sector development activities including those focused on the mental health workforce, NDIS, co-occurring mental health and alcohol and other drug use;
- projects that highlight the perspectives and experiences of young people and others with lived experience; and
- Community engagement including with Aboriginal communities.

All of these activities had deep input by people with a lived experience as consumers, carers or family members, and service providers.

The key intent of these recommendations - to balance the system with increased resourcing of prevention, suicide prevention and community support - have widespread support amongst mental health and community sector stakeholders and echo the recommendations of key peak bodies including the Western Australian Council of Social Service and the Youth Affairs Council of WA.

WAAMH acknowledges the significant contribution of our members, people with lived experience as consumers and family members, Consumers of Mental Health WA and Mental Health Matters 2 to this submission. WAAMH also acknowledges the Youth Affairs Council of WA, Shelter WA and the Western Australian Council for Social Service.

## 4. Introduction

Mental health reform requires a broad systems-based approach to build the full suite of services that combined make up a balanced and effective system that supports people to achieve good outcomes. The Mental Health, Alcohol and Other Drug Services Plan sets out the framework to do just that. We now need to turn state government investment to those service types most under-resourced - promotion, prevention and community-based recovery support - and to those people most urgently needing support for their recovery.

### 4.1 An unbalanced system

Across Australia and the world, communities, experts and governments agree we need to establish a new balance for mental health systems so that problems can be prevented, and people can find and access the support they need before reaching crisis point. International models demonstrate how to organise mental health services that respond to need where and when it is most needed, through increasing self and community based care, and reducing over-reliance on hospitals and specialist services <sup>i</sup>.

***“implementation of effective prevention, mental health promotion and early intervention activity across the lifespan is essential to turn the system around”***

***MHAOD Plan, page 10***

Prevention, early intervention and mental health promotion have been identified as key areas for increased investment by governments nationally. The Investing to Save report by Mental Health Australia and KPMG, which outlines the economic benefit of mental health reform in Australia, identifies “Invest in prevention, early intervention and promotion” as one of three key recommendations for mental health reform nation-wide and states that mental health investment needs to shift away from acute or crisis responses and towards prevention and early intervention <sup>ii</sup>.

The MHA and KPMG report identifies that over time, investment in early intervention generates a clear shift in mental health spending, with spending on acute care reducing over time and return on investment greatest where the interventions are provided to those with mild or emerging mental health conditions. For example, the report notes that:

- Preventative or early intervention for 50,000 children and young people experiencing an initial onset of depression or anxiety, or at risk for depression, would cover its costs in the short term and deliver \$200 million in long-term benefits (with a return on investment of \$7.90 for every \$1 spent);
- Early interventions for individuals experiencing initial onset of psychosis would save \$90 million in the short term (with a return on investment of \$2.30 for every \$1 spent) and \$270 million in long-term benefits (with a return on investment of \$10.50 for every \$1 spent) (p.64).

Other evidence, this time about specific programs, also demonstrates significant benefits:

- A saving to the WA hospital system of \$84,000 per person per year through preventing acute mental health admission by providing housing with linked community mental health support - with the saving realised in the first year <sup>iii</sup>;

- Increasing participation in employment from 23% to 61% with evidence-based employment support <sup>iv</sup>.

Simply, prevention and early supports that keep people living well in the community are urgently needed. Acute services are the most expensive way to address mental health and will remain unable to meet demand without change. A more balanced system will enable earlier access, prevent worsening mental health, ease pressure on emergency departments and acute beds, and reduce associated increasing public system costs. With WA’s emergency departments unable to respond to a growing crisis, and hospital beds experiencing rising challenges in delivering holistic recovery services and seamless pathways back to community living, the time for change is now.

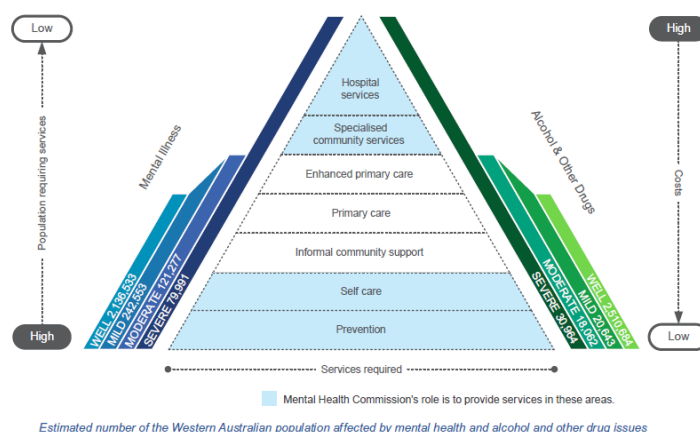
Western Australia has a bipartisan government plan that provides the roadmap to achieve this – the Western Australian Mental Health, Alcohol and Other Drugs Services Plan 2015 – 2025 (the MHAOD Plan). This plan includes in its principles: “a primary focus is on rebalancing services between hospital-based and community-based: moving services to the community where clinically appropriate” <sup>v</sup>.

### Vision and Mission

Our vision is to achieve a Western Australian community that experiences minimal alcohol and other drug-related harms and optimal mental health.

We do this by being an effective leader of alcohol, other drug and mental health commissioning, providing and partnering in the delivery of person-centred and evidence-based:

- Prevention, promotion and early intervention programs;
- Treatment, services and supports; and
- Research, policy and system improvements.



**Figure 1: MHC Vision. MHC Annual Report 2017-18**

However, despite plans to prevent mental health problems before they start, successive governments have failed to substantially invest in this area. While mental health has received additional spending overall, Government has focused these resources on acute and sub-acute services, continuing the existing structure of a system unable to keep people well or respond to the thousands of Western Australians seeking support in the community each year.

Our system is fragmented, with increasing calls from clinical and community stakeholders to address coordination and integration, develop real care pathways, and build better consumer and carer participation in service design and delivery. Work to integrate mental health and alcohol and other drug (AOD) prevention, services and treatment is also urgently required.

The development of necessary foundational strategies is nearing completion; these include:

- Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2018-2025 (Workforce Strategic Framework);

- Western Australian Mental Health, Alcohol and Other Drug Accommodation and Support Strategy 2018-2025 (Accommodation and Support Strategy); and
- Western Australian Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025 (Promotion and Prevention Plan).

These strategies pave the way for the implementation of a comprehensive system balancing agenda, and we anticipate detailed implementation plans for these strategies this year.



## 5. Resourcing

In the context of the State's improving finances and increase in GST revenue expected from 2019-20, we anticipate the opportunity for government to invest in mental health in the next 12-24 months. New targeted growth investment, combined with effective use of existing spending, should resource focused reform that occurs in a timely, planned and staged way to achieve a balanced system.

The Plan includes an action to divest Graylands Hospital, recommending that proceeds be used to develop contemporary options and facilitate transition to community for people currently in Graylands. WAAMH and other key stakeholders continue to support the Government's earlier commitment to ensuring funds from the sale of Graylands are re-invested back into the mental health system <sup>vi</sup>.

The Graylands divestment process and associated investment decisions must include attention to mapping the infrastructure, pathways and supports required to enable community inclusion and improved recovery outcomes for people with long term higher support needs, as a matter of priority. Their needs must be considered and planned in advance of the Graylands divestment process, with consideration to the recent shifts in psychiatric hostels that may emerge into further shifts in hostel provision into the future.

### Commitment sought:

- A. Proceeds from the divestment of Graylands are re-invested back into the mental health system.

## 6. Priority Area 1: Effective Mental Health Prevention and Suicide Prevention

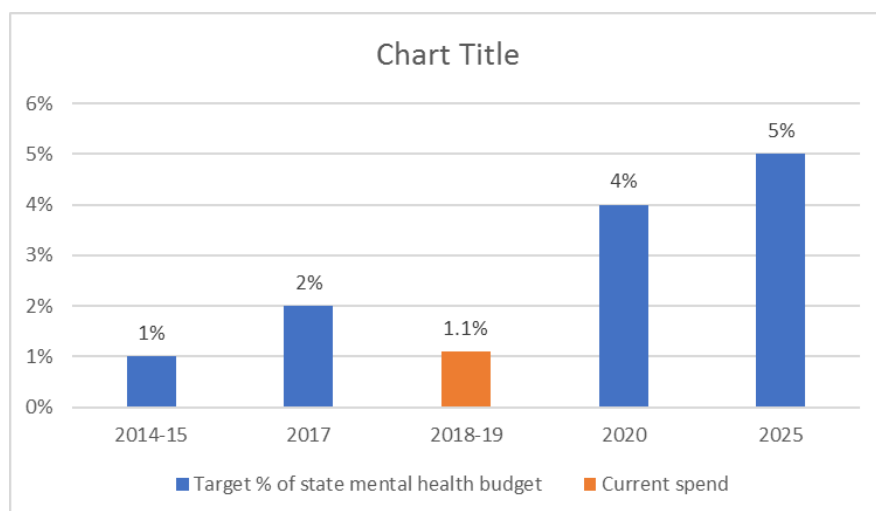
*“Not sure if prevention is the focus of state mental health. The community doesn’t believe or trust that the current mental health system does prevention but sees this system as an institution who hospitalises and medicates.”*

*Remote Aboriginal Medical Service, 2018.*

### 6.1 Mental Health Prevention

The MHAOD Plan states that current investment in prevention services and programs is too low and emphasises that significantly more funding is required to be effective.

The MHAOD Plan identifies the optimal mix of prevention funding and set specific targets for the proportion of **state mental health funding** needed for prevention to achieve good mental health outcomes for Western Australians. To achieve a balanced system the proportion of state mental health funding spent on prevention needs to grow from around to five per cent.

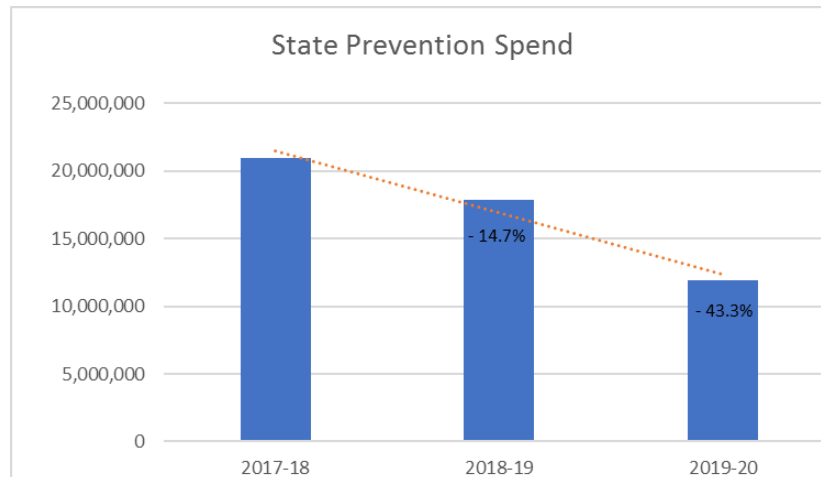


**Figure 2: Targets for the Proportion of State MH Funding allocated to Prevention**

Unlike for other support types, the Plan assumed prevention funding would be entirely the responsibility of the state rather than a shared responsibility with the Commonwealth. The Plan estimated the funding needed for prevention by 2025 as:

- State funding: \$89.2 million; and
- Other funding: \$0.0 million.

Despite these targets, there has been no sustained increase in mental health and suicide prevention by successive state governments for more than five years, with recent budgets instead making major cuts:



**Figure 3: State Prevention Funding Cuts**

The 43% cut over two years slated for 2019-20 is in large part due to funding ending for Suicide Prevention 2020 in 2019; this lack of commitment to suicide prevention in the Forward Estimates alongside no public statement yet made about government's intentions, is of major concern to stakeholders.

This pattern of chronic underinvestment in mental health and suicide prevention must end. Conditions for change are ripe. The new Promotion and Prevention Plan sets a strategic direction for prevention as an essential and under-invested component of a balanced system, and government narrative indicates a continued intent to move towards the prevention funding targets.<sup>vii</sup> What is now needed is a program of planned growth in prevention funding to reach the targets; necessary to enable effective implementation of the Promotion and Prevention Plan.

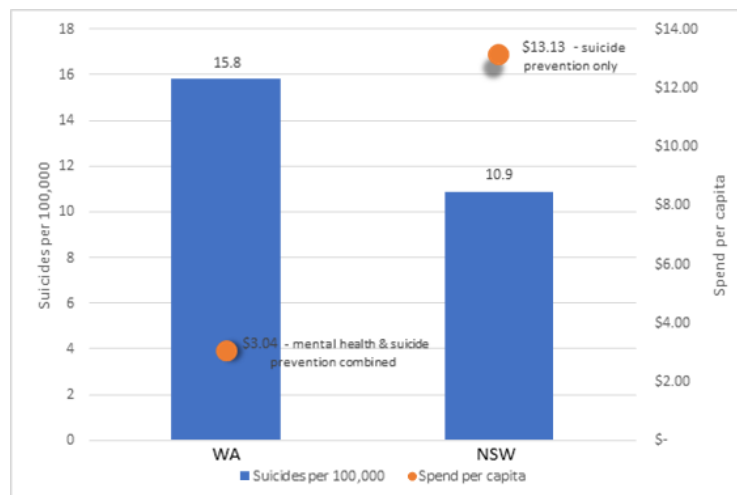
### Commitment sought:

- B. New prevention investment in 2019-20 to reach the unmet 2017 state funding target of 2%, and demonstrated increases over the Forward Estimates to reach the target of 4% state funding by 2020-21.

## 6.2 Suicide Prevention Funding

Rising suicides in Western Australia – up from 300 in 2008 to 409 in 2017 – are causing intolerable distress and trauma. These appear to particularly affect Aboriginal people, people in rural and remote areas, adolescents and young people. There is growing pressure from the community, media, and mental health stakeholders to reduce the hurt and harm caused.

At current funding of \$25.9 million over 4 years from 2015-16 – 2018-19, WA's investment and effectiveness in preventing suicide lags behind other more effective jurisdictions, notably NSW at less than a quarter of spend.



**Figure 4: WA Mental Health and Suicide Prevention funding compared to NSW Suicide Prevention funding**

This funding is scheduled to end in June, with no commitment as yet in the Forward Estimates. WAAMH is concerned that no public statements have been made to date indicating the government's commitment to suicide prevention despite community and parliamentary pressure.

WAAMH endorses the critical role of evaluation to inform future evidence-based strategy and investment and recommends gap funding to guarantee continuity of support for the suicide prevention services currently expected to end in June 2019. This will enable continuation of critical programs while the evaluation is completed, and a new strategy and long-term resourcing plan is developed. Any funding gap between strategies would result in people losing access to support with lives at risk, and program and service infrastructure dismantled.

This is time we cannot afford to lose. Suicide prevention stakeholders in WA have advised WAAMH that a failure to plan for the end of the previous One Life WA Suicide Prevention Strategy 2009-2013 led to these exact issues, with considerable breakdown in trust and relationships as a result of discontinued funding and a failure to develop a new Strategy in a timely manner. These consequences cannot be tolerated in WA for a second time.

### Commitment sought:

- C. Guaranteed continuity of funding for all programs under Suicide Prevention 2020, while a new Suicide Prevention Strategy is developed. Funding should match this year's resource allocation to Suicide Prevention 2020, equivalent to \$25.9 million over 4 years.

## 6.3 A New Suicide Prevention Strategy

### Siloes and fragmentation

There is a plethora of programs and models in prevention and suicide prevention, complicated by a range of funding streams. Stakeholders report concerns about the extent and consistency to which programs are evidence based, with some providing little depth or follow through beyond light-touch information.

Most prevention programs lack integration with mental health and AOD services, and stakeholders report little understanding of the role and programs across these parts of a disjointed system. In suicide prevention, despite grass roots coordination initiatives, at the systemic level there are multiple funding streams and initiatives for different regions, cohorts and different models and programs. As a result, efforts remain fragmented and complex.

Prevention and suicide prevention initiatives need to be planned, designed and coordinated at a structural level, across state and federal initiatives and with pathways to mental health and AOD community and clinical services.

### Priority needs

More approaches that address the social determinants of suicide, mental health and wellbeing are needed to help people deal with the causes of and contributors to mental health and AOD problems. The most common issues raised by consumers and families in our consultations were poverty, trauma, homelessness and housing related stress, violence and other major life stressors.

While some promotion and prevention initiatives must remain universal, new investment must prioritise programs that assist people to overcome the social, economic and practical barriers they may face to enable them to initiate and sustain suggested steps over time to improve their mental health and wellbeing.

Stakeholders report that prevention and suicide prevention services on the ground remain sparse, especially those accessible and responsive to differing cultural groups and young people. Rural and remote stakeholders report an urgent need for more locally consumer-driven and community-based initiatives to reduce stigma, increase community capacity through education, and provide wellbeing enhancing activities that address social isolation and overcome practical barriers to rural access.

While online prevention initiatives are a critical aspect of primary prevention, barriers to accessing online information and support are widely reported including English language literacy, IT literacy, online access and mental health literacy. Capacity building is needed for many consumers and family members to find, choose and use these programs effectively.

Postvention is still needed for proactive and effective follow up after suicide attempts and from ED and inpatient services:

***“Local Community Elders have complained about the lack of response for suicide and suicide attempts in their communities.”***

***Metropolitan Service Provider***

New mental health and suicide prevention funding should prioritise local, rural and regional models and providers, to ensure local relevance and cultural security. It must drive Aboriginal led solutions focused on social and emotional wellbeing, through procurement arrangements and capacity building to support growth in effective social and emotional wellbeing, mental health and suicide prevention initiatives by Aboriginal Medical Services.

We also recommend an urgent commitment to a new Suicide Prevention Strategy that builds on the Suicide Prevention 2020 evaluation, with additional and significant resourcing.

A new Suicide Prevention Strategy must:

- build on the learnings of the current Strategy's evaluation;
- be genuine co-designed with consumers and carers/families to ensure value to government and responsiveness to their needs;
- be established on evidence-based initiatives;
- prioritise local, rural and regional models and providers, to ensure local relevance;
- drive Aboriginal led and delivered services;
- provide a clear model for the integration of mental health and suicide prevention with mental health and AOD services;
- address the social determinants of mental health and suicide; and
- specify how future programs will be planned and integrated with federal initiatives and establish co-commissioning frameworks with the Commonwealth.

### Commitment sought:

- D. A new Suicide Prevention Strategy co-designed and completed by December 2019 to direct future strategy and investment.

## 7. Priority Area 2: Accessible and Responsive Community Support

### 7.1 Why community support

***“We need more support services to prevent people going back into hospital”***

*Family member, WAAMH consultation 2018*

Quality community support services provided by peers and recovery workers help people build recovery plans, reach personal goals and live valued lives in the community. They support each person on a recovery journey that is unique to them and led by them, their family members and carers (where appropriate), with the service care providers acting as supporters and enablers. Some assist carers and families to protect their own health and wellbeing and sustain them in their caring role.

***“One day I was incredibly fortunate to see a flyer for the community mental health group Grow. The next day I managed to get myself to my first Grow meeting. For the first time in my life I realised that other people suffered the same way I did. There was no longer any need for hiding the truth of how I felt inside. Grow gave me hope and a tangible belief in a future of real possibilities.”***

*Michele, WAAMH Recovery Stories Project*

Community support services are distinct from community based public mental health services such as outpatient services. They can however work effectively alongside any clinical services that the person may also access, to support an integrated approach to recovery. Without these services the benefits of any acute treatment can quickly be eroded, resulting in escalation and readmission.

Prevention, early intervention and community support contribute significantly to people’s emotional and social wellbeing and to a financially sustainable health system, saving money and lives<sup>viii</sup>. Without investment in treatment and recovery services in the community people can become increasingly unwell, and to get help need to access hospital beds or present to far more costly emergency departments<sup>ix</sup>. The National Review of Mental Health Programmes and Services cited high rates of emergency department admissions and readmissions to acute psychiatric services as evidence of “failure to provide timely and adequate community-based mental health supports” in WA.

Unsuccessful attempts to access community support, due to waiting lists or restrictive program criteria, have been linked to tragic deaths of West Australians this year alone. It’s clear that this approach is not working, with WA’s public hospitals having the worst record in the country for keeping mental health patients in emergency departments while they wait for specialist care<sup>x</sup>.

Acute and emergency services focus on clinical outcomes but are unable to provide long term care and support. Consumers and family members report that acute and emergency services fail to address stigma, or to effectively support them to progress many valued aspects of their personal and social recovery such as a safe and stable home, financial security, relationships, jobs or learning opportunities, and community belonging.

Consumers, carers and family members also report their rights, dignity and respect to be most often compromised in emergency departments and hospital-based services, which still have a long way to go in the cultural change necessary to work with people with lived

experience as partners in care and support, in challenging environments often not designed for mental health crises.

Better outcomes for people come through services and supports that address all components of recovery and the WA government’s Mental Health Outcomes Statements. Better outcomes for people can be achieved through support in the right place - in their homes and communities; at the right time - early, preventing the need for hospital admission; and by the right people - peers and recovery workers who provide compassionate recovery support and hope.

## 7.2 Limitations and Opportunities – the National Disability Insurance Scheme

The National Disability Insurance Scheme (NDIS) is a welcome reform that will provide lifelong psychosocial support to some people with mental illness in the community, providing hope for recovery.

However, it would be a mistake to wait until the impact of the scheme is clear before growing services that support people’s recovery. The NDIS eligibility rules limit NDIS access to around 10% of people with mental illness who require ongoing community support. WAAMH’s analysis suggests that around 6,500 West Australians will be eligible for a NDIS funded plan, but between 20,000 - 29,000 people who need ongoing psychosocial supports will not be eligible <sup>xi</sup>.

With Commonwealth investment in open-eligibility community mental health supports ending, large service gaps are emerging. While some new funds have been identified to replace transition programs, providers report these are insufficient to cover statewide needs. Although the conclusion of NDIS roll-out and federal program transition is not yet complete, it is clear that profound community support gaps will remain and may worsen.

*“Services are evaporating in local communities. What was there has been rolled into the NDIS. No NDIS funded plan means no services at all for people in small towns.”*

*Mental health consumer, WAAMH consultation July 2017.*

The Plan’s estimates showed community support will require **state funding contribution of \$245 million, with an additional \$201 million federal funding needed** (to meet 2025 demand), and WAAMH anticipates that the Commonwealth investment will come primarily from the NDIS. Compared to an existing state spend of \$34 million, the gap is stark - immediate investment is required <sup>xii</sup>. While the MHC is expected to release revised figures in its forthcoming Two Year Plan Update with relatively minor adjustments expected to occur for population changes, even if the best scenario for NDIS access occurs WAAMH estimates that around three in five consumers will remain without the ongoing community support they need.

In this complex and shifting funding environment, it is more important than ever that State planning occurs together with the Commonwealth to map out a detailed plan to meet the existing and growing shortfall to improve consumer outcomes and reduce growing rates of emergency attendance and acute service readmissions in the longer term <sup>xiii</sup>.

Policy settings about NDIS-state interfaces will assist to maximise the benefits of the scheme for Western Australians with psychosocial disability. While the NDIA has a clear role



in supporting and enabling access, it is also the case that providing the evidence required for eligibility assessment is the role of clinicians. To support this a systemic and strategic approach by public mental health is required. At a recent NDIS Psychosocial Disability Government Stakeholder Workshop in Western Australia, clinicians sought both macro level frameworks and micro level tools to assist them to support mental health consumers with the evidence they require to test their eligibility for the scheme. Other jurisdictions, most notably Victoria, have established NDIS-Health interface lead workers and clinical guidance and tools. WAAMH recommends a similar approach is established in Western Australia.

### 7.3 Need for a new Balance

The Plan identified community support as a basic building block of an effective and balanced mental health system and the most under-resourced service type, meeting only 22% of demand <sup>xiv</sup>. Modelling undertaken for the Plan by state government showed that community support needs to grow from 8% to 19% of the service mix <sup>xv</sup>.

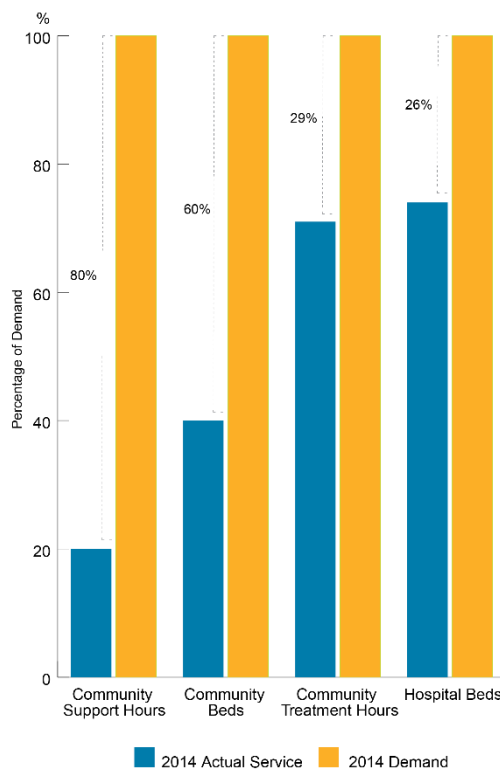


Figure 1: Current services as a proportion of 2014 demand (Mental Health only)

**Figure 5: In 2014 when modelling for the Plan was completed, only 20% of demand for community support was met, compared to 74% of demand met for hospital beds.<sup>xvi</sup>**

These needs remain. Consumers and families not already connected to services currently report an almost complete inability to access support prior to mental health issues escalating to the point of crisis or after acute care experiences. Even then the majority of consumers report services are hard to access, not available in their area, or that they do not meet the eligibility criteria.

Mental health providers have the same concerns. The majority report waiting lists from several months to 9 – 12 months, depending on the location of the service and the cohort the program is designed and funded to support:

*“I rang a community mental health service to find urgent support for my adult daughter after a suicide attempt and ED visit. They told me they had a waiting list and that she might get support in 9 or 10 months’ time. When I asked if there was anywhere else I could go, they told me all the support services had the same problem and referred us back to the public system. Months later, we’re still waiting.”*

*Family member, October 2018.*

*“We are experiencing significant demand for our Mental Health and Wellbeing services and are simply not able to meet this demand. Over the last 6 months we have had up to 240 people who have been referred, appear to be eligible and are awaiting assessment. Additionally, we have had up to 80 people who have been assessed as eligible and are waiting for a long-term worker. We are also undergoing an adjustment of FTE based on income and wage changes, and the transition of Personal Helpers and Mentors into NDIS. The result is that we will have even less staff available to meet community demand.”*

*Metropolitan Service Provider, October 2018*

Welcome investments in Step Up Step Downs services hold promise for reducing admissions, length of stay and readmissions. The focus on growing these services in the regions is supported, however these services still function at the point of escalating need and crisis, with early indications from a Victorian evaluation of the model demonstrating they do not comprise a solution to demand and flow<sup>xvii</sup>. Additionally, with current settings this model can only support people with short stay needs, people with stable accommodation to return to, and people in or able to travel to metropolitan and regional centres.

Intergovernmental plans agree that states and territories have responsibility for the ongoing community support needs of people with severe and ongoing mental health issues<sup>xviii</sup>, with the Commonwealth responsible for primary mental health services for people with mild to moderate mental health issues<sup>xix</sup>.

However there has been little real action to address the modelled need and consumers’ preference for community support that is focused on their goals and aspirations. Instead, successive governments have focused their efforts on increasing hospital beds and community bed-based services. While these are needed for an effective system, without a balance across all service types that collectively work to lessen demand, improve flow and deliver better outcomes, we will never be able to meet demand for acute and sub-acute services no matter the investment poured into them.

## Commitment sought:

- E. A planned program of incremental and staged state growth funding in community support, including accommodation with linked support, over five-years, that demonstrates how government will move towards meeting the modelled demand for services, with specific and staggered growth figures in the Forward Estimates.

This staged growth should be aligned to the demand and priority groups set out in the MHAOD Plan: people needing accommodation with linked community support, children, adolescents and young people, Aboriginal peoples, people living in rural and remote areas, and people with co-occurring AOD use.

Growth services should be co-designed and emphasise peer-based models of support including approaches that offer healing and pathways to real jobs and education, and be genuinely co-designed with consumers, carers and family members.

#### 7.4 Improving outcomes of existing services

WAAMH recognises that greater investment in community support will require improved quality and integration of current services across the whole system. There are multiple stakeholders with responsibility to achieve this. Levers that can enable genuine partnerships and more flexible, responsive services include quality standards and strategic procurement and contracting processes. As the community sector peak body, WAAMH also has a role and will ensure a stronger focus on sector stewardship and quality going forwards.

Government's role could consider the use of targeted capacity building to local providers and Aboriginal organisations, use of procurement levers to facilitate genuine partnerships, and extending the capacity building of community mental health organisations through, for example, extension of the Looking Forward Moving Forward Project.

New models, and procurement processes associated with existing services, should also attend to the need to better integrate services within the system. There is a further need for to design and implement system navigation supports to support consumers to access existing resources and supports:

*"I've been trying for days to help someone. There is no go-to person. I have had to talk to so many people. There doesn't appear to be any service that can smooth the way. So sad. So frustrating. Who can I go to?"*

*Message to WAAMH social media, 2018*

#### Commitment sought:

- F. Procurement reform and targeted capacity building to support and improve the relevance of existing funded programs to the local and cultural needs of Aboriginal, rural and remote communities.

## 8. Priority Area 3: Accommodation with linked community support

Inadequate access to social and public housing, with linked mental health support, is a major social issue. The MHAOD Plan estimates that by 2025, between 1474 and 1867 Western Australians who have mental health, and/or alcohol or drug issues will also be homeless. Consumers, families and clinicians all report that integrated and coordinated action across government and providers is urgently needed to increase access to safe and stable homes with linked support.

***“I know many families who have adult loved ones living with them because there are no homes or supports for them. What will happen when they pass on?”***

*Family member, 2018.*

With the forthcoming Accommodation and Support Strategy now close, the rationale and building blocks for improving access to accommodation with linked community support are clearer. What is now needed is a planned program with specific and timed actions to improve existing services to achieve better outcomes for people, and to reduce service gaps through new investment in accommodation with support.

Improving existing services is a priority. Targeting WAAMH’s existing sector development resources could support funded programs to improve quality against contemporary standards, strengthen competencies to

respond to people’s multiple needs including co-occurring AOD use, and explore improved and standardised intake and referral practices to enable better access and pathways between services.

Existing government resources could be utilised to develop coordinated and integrated plans across government, that specify joined up actions to address the housing crisis for people with mental health issues. Existing government resources could also develop more responsive and flexible contracts and procurement processes to enable, for example, a more realistic length of stay in some programs; this would enable providers to support people who are currently ineligible for programs and need long term recovery support prior to transition to lower support models.

WAAMH’s consultations indicate several priority groups most in need of accommodation with linked community support: young people with multiple unmet needs, people with co-occurring AOD use, people in rural and remote areas, and people who need support to transition out of hospital or community based institutions, or to remain in the community. People in housing often require access to supports to maintain their tenancy.

Strategic additional investment is required to map and research priority gaps in depth, improve connections between community managed and clinical services, and to work with consumers and carers to co-design new programs and models of support. As an independent entity with strategic connections across clinical and community providers WAAMH would be well placed to conduct this work. Revenue from Graylands could be channelled into supported accommodation infrastructure and time-limited sector development activity in supported accommodation services to ensure best value is gained from existing spend.



**WAAMH**

Western Australian Association  
for Mental Health

### Commitment sought:

- G. New resources to complete the foundational reform work set out in the draft Accommodation Support Strategy to ensure existing accommodation services with linked support are integrated with clinical services, provide transition and flow between different options, and improve people's mental health outcomes.  
Cost: \$295,000 over two years.

### Commitment sought:

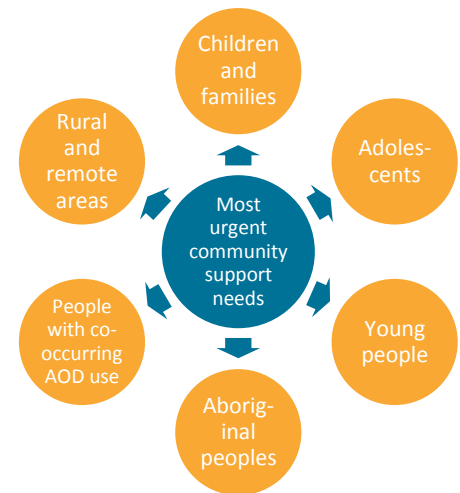
- H. Ensure that Commitment E - a planned program of incremental and staged state growth funding in community support over five-years – includes growth in accommodation with linked support.

## 9. Priority Area 4: People most in need

### 9.1 Children and families

While data on funding and programs is not readily publicly available, few community supports targeted at children and families, or whole of family recovery and healing programs appear to exist in Western Australia.

The Plan noted that dedicated community support services for children and young people are a high priority, as are supports for children who have parents with a mental health problem. WAAMH suggests that more needs analysis is required, including a strong component of children and family engagement.



### 9.2 People living in rural and remote areas

*“We literally are travelling over four hours to seek help each week as we have to see a psych in Perth as there is no one in our area. It is very costly and impacts on our lives greatly. Please create services where there aren’t any.”*

*Rural family member, 2018.*

People in WA’s small towns, regional and remote areas experience worse mental health and higher suicide rates but have far less access to services.

In WAAMH’s 2018 consultation of more than 220 consumers, family members and service providers across the state, the top reported barrier to service access was a lack of community support, followed by a lack of prevention services. People identified the main factors impacting their mental health as AOD use, social isolation, stress, unemployment and stigma.

The MHAOD Plan showed that community support needs in regional, rural and remote WA needs to grow to 1.35 million hours by 2025. This means we need almost twice as much community support in country areas as we currently have for the whole state. While data is not publicly available to compare to the amount of services available now, stakeholders report much of the funding is provided in metropolitan areas, with some places having no state funded community supports at all. While better ICT services are needed, technology is not a panacea – with many people preferring the chance to build a relationship with a skilled worker to support their recovery.

Work is needed to support and improve the relevance of support options available in local and cultural needs and communities and the sustainability of small, locally based providers. Levers include procurement reform that prioritises genuine partnerships, and local knowledge, connections and experience, and capacity building to facilitate a level playing field for providers.

### 9.3 Young people and adolescents

Community mental health services play a crucial role in preventing the long-term mental health issues and psychosocial disability that people can experience without appropriate

support. Prevention activities such as school mental health awareness programs, early intervention services that support people when their first mental health symptoms become apparent, and ongoing community support services for young people to learn to manage their mental health throughout the lifespan all play a role. Combined, these elements are the best way to reduce the pressures on our mental health system into the future.

In 2018, WAAMH undertook a major project to look at young peoples' experiences of the mental health system in WA. It found that young people can have contact with many services and service systems, and navigation is complex and difficult, they place a high value on the relational capabilities of service staff. Young people showed resilience and a strong sense of personal agency, including taking action to get services to work together. Many recognised the need to persevere in connecting with support, and often keep going back to see someone else even after they have had a negative experience.

Stakeholders report a complex and fragmented system simply unable to respond to young people's needs. Pressing needs are community based support for young people presenting in emergency and transitioning between hospital and community and accommodation with linked community recovery support for young people with co-occurring issues or other complex support needs.

The MHAOD Plan identified that young people should be prioritised early when increasing community support. WAAMH supports the development of a new Youth Stream and recommends that this facilitate and procure the range of service types sought by young people, including early intervention, peer-based models and community support.

#### 9.4 Aboriginal people

***“Shame and stigma – community led solutions are needed across the state for Aboriginal people.”***

WAAMH's consultations in metropolitan areas indicate Aboriginal people predominantly try to access emergency or hospital-based services only once their mental health has escalated to crisis point or after a suicide attempt. They report little knowledge of community support options available and how to access them, or that many services are not culturally secure.

In other parts of the state, the availability of mental health services varies greatly. Despite remote areas having a very large population of Aboriginal peoples, and unacceptably high suicide rates, there are no or few state-funded community based supports for Aboriginal peoples with mental ill-health, depending on the region. A WA Country PHN Needs Assessment identified that there is not a targeted and differentiated approach for Aboriginal people with mental illness. <sup>xx</sup>

Aboriginal people report they often need programs that respond to co-occurring mental health issues and AOD use, with many wrong doors reported and extensive waiting lists for the few services able to respond to these needs.

***“There is a lack of cultural awareness in organisations and many employees in organisations are unable to work in a culturally appropriate way... There needs to be more money put towards building collaborative relationships with Aboriginal organisations, education employees on how to actually work with these communities and funding community led initiatives within WA.”***

***Aboriginal Stakeholder, Rural and remote Consultation, 2018***

Culturally secure community support options that complement clinical approaches need to urgently increase for Aboriginal peoples. Mechanisms to achieve this include procurement reform a critical lever to prioritise Aboriginal led and delivered services. The Aboriginal mental health workforce needs significant expansion, and some Aboriginal Medical Services need capacity building to develop or expand their suicide prevention, social and emotional wellbeing, mental health and co-occurring AOD use programs. It is also necessary to improve the cultural safety of non-Aboriginal community support services through, for example, building on the learning of the Looking Forward Moving Forward program.

## 9.5 People with Co-occurring Mental Health and AOD use

*“People with both mental health issues and alcohol and drug problems have often bounced around services because there are very few that are equipped to truly support the whole person.”*

*Peak Body Project Coordinator*

Although 63% of people who have an AOD issue also have some sort of mental health challenge, it is the experience of many people treatment or support for the complexity of both issues is rarely holistically available. Both systems often require treatment or stabilisation of one issue prior to service access for the other, or in parallel. Despite long acknowledgment of this issue, complicated referral pathways remain a problem. The structural differences between the AOD treatment sector and the community mental health sector include differing service models, historical practices and funding silos, which make it challenging to fund or provide holistic services. In turn the fragmentation causes significant difficulties for consumer navigation and joined-up care.

Lack of access to AOD services, including rehabilitation services, and services that cater for co-occurring mental health and AOD issues are a recurring theme in WAAMH’s consultations with people and providers in rural and remote WA. AOD problems were identified as the a major issue that affects mental health, with 83% of respondents identifying this a problem in their community. In a report released by the Royal Flying Doctors Service in 2017 the need to address alcohol and drug issues in regional communities was also identified in the top three priorities for improving health in regional areas in Australia, signifying the importance of this area <sup>xxi</sup>.

WAAMH welcomes emerging needs analysis and commissioning processes to provide integrated services and recommends this priority population receives additional and early focus when government increases community support programs.

### Commitment sought:

- I. Growth community support, accommodation with linked support and prevention funding ensures the needs of vulnerable groups are prioritised in planning and delivery of new options.



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- <sup>xi</sup> While the exact figures of people who need ongoing psychosocial support are unknown, the Productivity Commission estimated approximately 200,000. The National Mental Health Service Planning Framework modelling estimated that 290,000 Australians with mental illness require community support.
- <sup>xii</sup> Figures are for both mental health and AOD community support. Government of Western Australia, Mental Health Commission. (2015). Better Choices Better Lives. Western Australian Mental Health, Alcohol and Other Drugs Services Plan 2015-2025. Page 215.
- <sup>xiii</sup> WACOSS
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